Reimagining Public Health Advocacy

Findings from a National Scan of Public Health and Community Power-building Groups

HUMAN IMPACT PARTNERS

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Human Impact Partners (HIP) transforms the field of public health to center equity and build collective power with social justice movements. Learn more at http://www.humanimpact.org.

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Overview

Drawing on a national scan of nongovernmental public health and community power-building groups,[1] this report explains how we at HIP approach our work to shift the field of public health, the research we conducted to better understand the gaps between public health and community power-building organizations, and the implications of what we've learned. We hope that as we collectively build these relationships across the country, public health solidarity with social justice movements will feel more natural, possible, and desirable.

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1 In this report we define community power-building organizations (CPBOs) as the entities that take on the work of building and organizing a base of impacted people to take collective action to transform their material conditions. See page 11 for a more detailed description.

Preface: Fighting for Housing as Health

During the pre-vaccine days of the COVID pandemic, public health authorities urged us to shelter in place in our homes and minimize contact with others. Yet millions of people across the country were unable to heed this advice. Throughout 2020, due to lost or reduced income and an economy in turmoil, tenants fell further and further behind on their rent payments and faced the threat — and oftentimes, the reality — of eviction. How do you stay safely at home when you need to keep working to pay rent? When you don't have a home in which to shelter?

The strong correlation between housing and health predates COVID, but the pandemic made the consequences of eviction more widespread, deadly, and visible. Facing these impacts, tenants and grassroots organizers around the country began to call for eviction moratoria, and federal, state, and local governments began to pass protections.

At the federal level, Congress included a 120-day moratorium on evictions for tenants in properties with federally backed mortgages and housing that received federal assistance in the March 2020 CARES Act. As this limited protection took effect, housing advocates and public health practitioners came together to push for broader and more sustained protections.

On September 1, 2020, the CDC announced a nationwide eviction moratorium for renters who met specific income criteria and were unable to pay rent due to economic hardships related to COVID. The moratorium was in place from September 4, 2020 to July 31, 2021 and re-implemented in a more limited form from August 3, 2021 to October 3, 2021. Unlike the CARES Act moratorium, which was limited to federally backed properties, the CDC moratorium applied to nearly all rental properties nationally.

During this period and beyond, eviction protections and rental assistance programs passed at the state and local level complemented and extended the federal moratorium. In California, a state with some of the longest and strongest protections, legislators passed a series of moratorium extensions through June 2022, with some local protections extended into 2023.

These policies protected health and saved lives. Studies found that states that kept an eviction moratorium in place had half the infections and one fifth of the deaths of those that allowed evictions to proceed.[4] Protection from COVID was far from the only benefit; mental health, food security, overall self-reported health, and racial equity outcomes also improved when evictions were curtailed.

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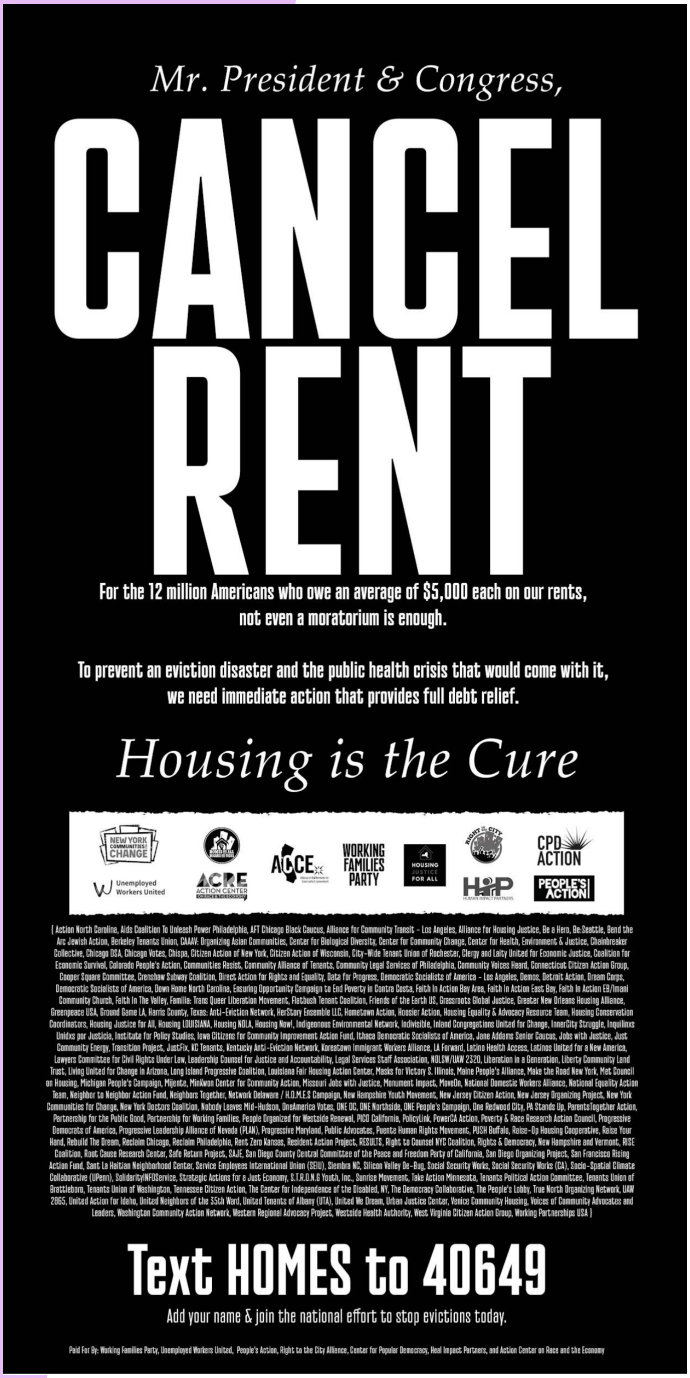
2 Kathryn M Leifheit, Sabriya L Linton, Julia Raifman, Gabriel L Schwartz, Emily A Benfer, Frederick J Zimmerman, Craig Evan Pollack, Expiring Eviction Moratoriums and COVID-19 Incidence and Mortality, American Journal of Epidemiology, Volume 190, Issue 12, December 2021, Pages 2503–2510, https://doi.org/10.1093/aje/kwab196



Human Impact Partners (HIP) participated in national, state, and local eviction moratorium advocacy campaigns to enact these protections alongside many partners, including the Right to the City Alliance, California's Housing Now! coalition, Tenants Together, the Bay Area Regional Health Inequities Initiative (BARHII), Berkeley Media Studies Group (BMSG), PolicyLink, and many others.[3] At both the federal and state levels, we saw public health organizations join forces with housing justice movements to make a clear case for moratoria, and to successfully preserve COVID protections during the long and uneven recovery.

At the federal level, HIP worked with organizations to encourage partners across a range of sectors to use their existing platforms and influence — no matter how large or small, how public or behind-the-scenes — to pressure the incoming Biden administration to extend the 2020 eviction moratorium and provide rent relief. To highlight the issues at stake and bring more organizations to the table — especially across the health sector — HIP and partners held a national briefing in December 2020 to provide evidence of the link between health and housing, featuring community organizers, funders, public health, hospital systems, nursing union leaders, academic researchers, and tenants' rights and housing justice organizations. We also joined power-building partners in direct advocacy and placed a full-page ad in *USA Today* calling on President Biden and Congress to "Cancel the Rent," framing housing as a cure for the COVID public health crisis.

3 For more details about the California partners' advocacy on this issue, see the Berkeley Media Studies Group December 21 blog post, "Six Media Advocacy Lessons from a Campaign for Housing Justice and Health Equity" by Heather Gehlert and Katherine Schaff. Available from: https://www.bmsg.org/six-media-advocacy-lessons-from-a-campaign-for-housing-justice-and-health-equity/.

In California, public health groups were even more successful in flexing their power and leveraging their data alongside housing organizers to close loopholes in the state's eviction moratorium and extend it three times. This was due in part to the strong, pre-existing relationships among the partners involved, each of whom contributed different types of expertise to the shared goal of strengthening and extending the eviction moratorium. These relationships allowed partners to quickly identify spokespeople with a variety of lived experiences and perspectives to tell compelling stories that resonated with a wide range of audiences. The joint advocacy also created multiple opportunities for public participation, including signing joint letters, offering testimony with coaching and training, and conducting and publicizing rapid-response research. Roles encompassed varying levels of experience, capacity, and bandwidth, allowing a range of ways to engage.

Public health practitioner and organizational participation in eviction moratoria advocacy at local, state, and federal levels highlights what can be won through consistent political pressure, when skillfully and strategically applied. In particular, these partnerships illustrate how public health can align with community power-building organizations to address the social determinants of health in ways that are more effective than when each works alone. In this way, **the pandemic showed us what can happen when public health uses its credibility, influence, and power in a more significant and strategic way to address the social determinants of health**. Public health can leverage real power to not only create better health outcomes, but to directly address the root causes and injustices that produce health inequities.

Amidst the devastation it caused, the pandemic catalyzed a series of experiments across the country that clarified what is possible in terms of alleviating child poverty, reducing food insecurity, improving health, protecting tenants, implementing workplace protections, and decarcerating from jails, prisons, and detention centers. The pandemic revealed that our society is capable of taking powerful actions to save lives and protect each other, even when they upset the *status quo*. But as the pandemic and halting recovery period stretched on, industry and politicians pushed to return to "normal" — leaving millions jobless, unable to pay rent, and with endless medical bills.

Reflecting on this and on our experiences of linking public health advocacy to social justice movements, HIP wanted to examine what we could do to build on our successes and avoid missed opportunities in the future. Looking back from where we are now in 2024, we are in a position to ask and answer some critical questions: What could have been possible if we had even stronger advocacy structures within the public health field and deeper collaboration with social movements? **What could have happened if we had the power to insist that we would never go back to normal, that normal had never worked for communities facing pre-pandemic health inequities?** What new future could we have charted? Those questions led to the research and findings described in this report.

HIP's Approach to Public Health

Public health seeks change across many realms: changes in risk and protective factors, changes in nonclinical and social drivers of health, and changes in the underlying structures and material conditions that shape the social determinants of health across sectors and systems.

Historically, changes of any significant magnitude to those underlying conditions have arisen from social movements embedded in broader responses to injustices, such as movements for labor, civil and voting rights, and environmental justice. Yet for most public health practitioners, the idea of engaging deeply with political movements as an effective way to accelerate change is largely unexplored, and even uncomfortable. At HIP we've found that some public health practitioners *do* approach acts of solidarity as necessary and even core to public health practice — but many more do not. Most community power-building organizations, on the other hand, understand and act on the premise that organized social movements are required to yield the shifts in power necessary to transform the conditions driving inequities. The gulf between these two worldviews is a missed opportunity for reimagining public health's role and power to achieve the change it seeks.

At HIP, we work to reimagine the public health sector's relationship with social change. We envision a public health movement that deeply partners with — and provides infrastructure to support — community power-building organizations and networks. In our view, public health practice is most effective when we design our work to shift, share, and help build the power of those most impacted by injustice to transform the economic, social, and environmental conditions that determine our health. We focus on four main issue areas in this work: community safety, economic justice and worker power, housing justice, and climate justice.

We know that **advancing equity requires confronting the unequal distribution of power, and dismantling systems of advantage and oppression** that produce and maintain inequitable conditions. We also know that sustainable, long-term change occurs because of social movements that chip away at these structures until they crumble, while visioning and building new, just systems. We want the field of public health to see itself in these movements; to see the field's power and potential to align with social justice movements leading the fight to advance health equity.

We are not alone in seeing strong links between community power and health. For example, the Lead Local initiative, of which HIP was a partner, brought together local and national power-building leaders from the fields of community organizing, advocacy, and research to explore the relationship between community health and power-building. We use Lead Local's definition of community power — the ability of communities most impacted by structural inequities to act together to influence decisions affecting their lives[4] — and note that it is distinct from community engagement, where community members participate in, contribute to, and inform better decisions, without necessarily affecting who has power over decisions.

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4 *For more about the Lead Local Collaborative, visit https://www.lead-local.org/.*

How does community power translate to better health? It gives people a sense of agency and autonomy over their lives. It also creates a sense of belonging and connection. Most importantly, it positions those most impacted by inequities as those most capable of identifying solutions. **All of these aspects of community power contribute to healthier lives and thriving communities because they transform the underlying conditions that produce health.** As noted by the Lead Local initiative, community power-building "is particularly critical for underserved, underrepresented, and historically marginalized communities who have been excluded from decision-making on the policies and practices that impact their health and the health of their communities."[4]

Community power-building organizations (CPBOs) are the entities that take on the work of building and organizing a base of impacted people to take collective action to transform their material conditions. Typically, CPBOs build a base of support and advocacy centered around a place (e.g., a neighborhood or city), demography or identity (e.g., workers, youth, people formerly incarcerated), and/or specific issues (e.g., workers' rights or environmental justice). CPBOs may also be referred to as grassroots organizations, community organizing groups, base-building organizations, or movement-building groups. By any of these names, they share a focus on changing the conditions impacting their members, and using advocacy as one of many tactics in pursuit of their goals.

Some public health frameworks have grappled with the inequitable distribution of power as a driver of the social conditions that determine health. However, these frameworks generally do not consider the strategy of building community power as a way to shift conditions affecting health and well-being. Examples of such conditions include tenants' rights to safe and affordable housing, workers' rights to fair wages and benefits, and everyone's right to community safety.

As we witnessed the disconnect between public health and community power-building movements, we also saw the potential for these two fields to work together to achieve racial justice and health equity. Strengthening these particular partnerships, we believe, will help both groups achieve their shared goals. Getting there will require some specific and significant bridge building. The following section describes our answer to the question of how to strengthen connections between public health and CPBOs, what we've learned in building these bridges, and ideas for moving forward.

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4 *For more about the Lead Local Collaborative, visit https://www.lead-local.org/.*

Our Research: A National Landscape Scan to Understand the Ecosystem

To understand what it would take for public health to build relationships with CPBOs and the wider social justice movements they lead, HIP designed a national landscape scan of public health entities and CPBOs. Because advocacy is central to this work, we focused on *nongovernmental* public health organizations because they lack the real and perceived political constraints often faced by governmental public health, such as restrictions on lobbying.

That being said, some of the lessons learned and implications for stronger partnerships apply to both governmental and nongovernmental public health organizations. Our work with public health practitioners via our Public Health Awakened network and other initiatives including many working within governmental public health demonstrates that many in government are eager to use their voices, expertise, and resources to build collective power.

With help from Frey Evaluation, LLC, HIP conducted interviews and online research with representatives of 35 CPBOs and nongovernmental public health organizations (referred to as public health NGOs in this report). For a full list of participants, see Appendix A.

We interviewed the 13 CPBO and national CPBO network representatives first. These organizations were known or referred to us from prior work in key issue areas affecting the social determinants of health: housing, economic/worker justice, climate/environmental justice, and/or community safety. During the interviews, we assessed where public health voices, analysis, advocacy tactics, and partnership could support CPBOs' campaigns and movements. We also explored CPBOs' understanding of how their work connects to public health organizations, their readiness to partner in the future, and what they might need in terms of partnership and relationship building. Finally, we asked specifically about their willingness to advocate for public health in the face of the current backlash against the field.

Next, we interviewed representatives of 22 public health NGOs, which were mostly large national organizations representing different aspects of public health and its workforce, as well as academic public health groups focused on training students and practitioners in advocacy. We also talked to representatives of public health coalitions and capacity-building groups. The public health NGOs were invited to participate based on HIP's assessment of their power and influence in the field, their demonstrated interest or capacity to support community power-building, and/or their known academic focus on building advocacy capacity. Two of the national public health organizations invited to participate in interviews declined; all of the CPBOs invited chose to participate.

Prior to interviewing the public health NGO participants, we conducted research to understand each organization's work on social determinants of health policy, the extent to which they use advocacy tactics, and their existing partnerships with CPBOs. Building on the interests and

needs expressed by CPBOs during the first set of interviews, we explored public health NGOs' capacity and willingness to partner with CPBOs, focusing on the use of advocacy tactics and working upstream to address underlying causes of health inequities. We also asked about the need for coordinating efforts with other public health organizations. More information on the Methods for this landscape scan can be found in the accompanying publication in *Health Affairs*, "Community Power–Building Groups And Public Health NGOs: Reimagining Public Health Advocacy."

What We Learned: Shared Aspirations, Divided Worlds

Through our work with both public health organizations and CPBOs, we're aware of a disconnect between these two fields. Our interviews affirmed our sense that the disconnect is real, but that there is also **tremendous potential for public health to build relationships with CPBOs, to support them with advocacy, and to show up for them.** When this happens — whether locally, regionally, or nationally — it will strengthen relationships, build trust, and result in the changes in material conditions that both public health and CPBOs aim to achieve.

Public health NGOs and CPBOs don't understand each other

A key finding from our interviews with public health NGOs is that **the field of public health (with some exceptions) is generally not familiar with community power-building as a concept.** Few public health NGOs have relationships with CPBOs or networks that are leading movements to transform social, economic, and environmental conditions that affect health and well-being. As a result, public health organizations both inside and outside of government tend to conflate community *power-building* with community *engagement*. Similarly, they tend to see community-based organizations as interchangeable with community power-building organizations.

Even for public health organizations explicitly working to address root causes of health inequities, the idea of using community power-building as an intentional, proven strategy to achieve social change remains unfamiliar, and often uncomfortable. As one interviewee explained, "Within the public health field ... there really isn't a real robust understanding of power, and need for power-building, and power as a determinant of health."

Public health's lack of familiarity with community power-building as a concept and strategy, as well as a lack of contact and relationships with CPBOs, feed into other disconnects between public health and CPBOs. One of these is centered around the language used to describe their efforts. CPBOs often describe their work in terms of justice (e.g., "climate justice," "environmental justice," "racial justice"), whereas public health tends to use the language of equity (e.g., "racial equity," "healthy equity.")

Language differences are not merely semantic; they often reflect profound differences in analysis and strategy. For example, public health housing initiatives may address health outcomes linked to specific housing conditions, such as smoke-free housing or removal of lead or mold. CPBOs are more likely to focus on the structures that underlie these conditions, such as tenants' rights, decommodification of housing, and the historical legacy of housing discrimination. Likewise, in the economic and workplace realms, public health might focus on workplace safety or providing wrap-around social services to low-income people whose wages do not cover basic needs like healthcare, food, and shelter. CPBOs might approach this same issue by trying to increase wages, expanding access to health care, ensuring corporate accountability, and building worker power to negotiate wages and conditions.

These differences in language, strategy, and outcomes are not in opposition to each other, so much as misaligned and uncoordinated — they have potential to be powerful in better alignment. Both groups work upstream, but at different points along the stream.

Just as public health organizations don't "get" CPBOs, the reverse is also true: **CPBOs don't get public health**. This is not unique to CPBOs — broader society has a murky understanding, at best, of what public health's role is. As one CPBO interviewee said, "I don't have a sense of what public health workers do every day."

Many CPBOs, again reflecting broader public opinion, view public health organizations narrowly as service providers (e.g., of immunizations, infectious disease testing, and low-cost clinical services), rather than as organizations committed to primary prevention and the types of changes that could address and improve social determinants of health. Equating public health with health care also raises the specter of harms perpetuated by both public health and health care entities. Many historically marginalized groups are keenly aware of extractive, abusive public health and health care research practices that have caused significant trauma and lasting harm. Many of these practices remain unaddressed and unreconciled, which continues to undermine trust and relationship building.

Another issue that is often unexamined within public health (and health care more generally) is an emphasis on individual behavior change that appears to blame people for their unhealthy behaviors. For example, diabetes prevention messaging may urge people to change their diets and physical activity routines without considering access to healthier foods or safe places to walk. When these narratives are perpetuated, they foster mistrust and undermine opportunities to join together to address the issues and structures that drive behavior. This focus on individual behaviors is at odds with many CPBOs' orientation toward collectivism, and can drive a narrative wedge between the two fields.

Although CPBO interviewees acknowledge and appreciate the framing of "social determinants of health" as consistent with their own campaigns for justice, they also see limitations. In particular, some note that public health appeared to act more boldly and decisively on structural policy issues during the pandemic than before or in the aftermath of that crisis. For example, public health called for halting evictions and enacting worker protections, and CPBOs saw that these policy stances are possible. The question becomes, why is support for these policies any less important now, when so many are still struggling with unjust housing and economic policies? As one CPBO interviewee told us:

> **There was some alignment especially at the start of COVID — people over profits, masking, disability justice framing, housing work — it seemed like an opportunity for radical change, but now we're in a space of COVID denialism, profit is still priority, and the health[care] system is still geared toward profit.**

Public health concerns about advocacy constrain their potential role supporting CPBOs

Skittishness about advocacy and lobbying is common across public health organizations, inside and outside of government, and creates barriers to partnering with CPBOs. As one public health interviewee acknowledged:

> **There's a tension with power-building organizations sometimes because of their level of advocacy involvement. Organizations like [ours] are trying to teeter the line, and sometimes choose not to go there. That's a big barrier that keeps us from working together a lot.**

Some public health NGOs do engage in advocacy and lobbying activities, but these are generally devoted to strengthening public health's resources, workforce, and infrastructure or specific health issues (e.g., smoking or sugar-sweetened beverages), rather than to support broader campaigns addressing upstream conditions, such as those in which CPBOs are engaged. The procedures for determining when to engage and advocate on a particular issue seem opaque for most of the public health NGO organizations we interviewed, with decisions generally defaulting to one or two individuals in leadership roles. As one public health NGO interviewee shared, "The Executive Director has a final say on everything. [The staff member] is a filter as requests are coming in. If it's controversial at all, we won't sign on unless we have a policy ... to support it."

Some public health organizations and schools of public health recognize that hesitancy around advocacy and lobbying limit public health's effectiveness, and are working to encourage more advocacy and build the skills needed for effective advocacy. For example, several academic public health programs are now focusing on teaching public health students and practitioners advocacy and lobbying skills, with some launching "activist labs." These are promising approaches to increase the motivation and skill set for advocacy within the public health workforce, while also connecting students and practitioners to current and future partners in social justice movements via internships, events, and joint projects.

In addition to general skittishness about advocacy and lobbying, particularly regarding upstream social determinants, some public health NGOs worry that they might duplicate existing advocacy efforts. Others were concerned about how to engage in or coordinate advocacy in ways that respect the preferences and needs of those closest to the issues:

> **I would really want to be vigilant and aware that this work is being led and deeply informed by the aspirations of BIPOC communities. It's easy to come into an initiative like this, really well intentioned, but then continuing to be led by the usual … or what might be organizationally beneficial.**
>
> **—Public health NGO interviewee**

CPBOs want to partner with public health and value their contributions

The CPBOs that had collaborated with public health entities described their experiences as largely positive, with the partnership adding value to their campaigns. In particular, CPBOs valued access to public health research and data, along with related advocacy to support their policy campaigns, describing public health voices as "validators" and "allies." This is particularly the case when data and research affirm the lived experiences of community members. While research, data, and validation are valued, there's also a tension in over-emphasizing or deferring to "expert" professional voices over those of community members with lived experience:

> **Validators are useful. Wish it wasn't that way. Directly impacted people should be heard in the same way, but some of these folks have more power. There's ways to do that accountably. Sometimes, our folks are brought in for just the story, not the solution.**
>
> **—CPBO interviewee**

CPBOs expressed particular interest in receiving the following modes of public health support and advocacy:

- Providing research and data reports
- Letter writing
- Providing testimony
- Speaking to the media
- Lobbying
- Mobilizing people
- Developing relationships
- Narrative strategy
- Linking public health and social determinants
- Providing or partnering to apply for funding

As noted above, public health NGOs do use these tactics, but not generally in support of CPBOs' issues and campaigns. For example, nearly all of the NGOs we spoke with generated research and reports, although some stated that they had difficulty getting their products to reach CPBOs. Letter-writing campaigns or signing on to others' letters was another common advocacy tactic that public health NGOs engaged in, although not necessarily in support of CPBOs' campaigns.

CPBOs said they would welcome increased and deeper collaborations with public health, particularly if public health develops a bolder sectoral presence at the national level. CPBOs have viewed public health as missing opportunities in national legislative and policy fights, such as the Fight for $15 livable wage campaign and the People's Response Act for non-carceral community safety. This will require some internal changes within large, national public health NGOs; several such organizations we interviewed, who have high levels of power and influence within public health, also described themselves as the least willing and least interested in participating in coordinated advocacy efforts to support CPBO movements and campaigns.

Public health and CPBOs could be much stronger together, countering shared threats

Public health entities inside and outside of government see themselves as beleaguered, especially following the wave of attacks on the field and harassment of public health officials and practitioners sparked during the pandemic. Attacks on public health's scope and authority have been undeniably difficult for the field. **Public health could benefit from a more expansive analysis of these attacks as part of a larger assault on the public sector, government, and democracy** — which in turn could help public health see itself as aligned with social justice movements more broadly. And partnering with social justice movements to fight back could bolster public health efforts considerably. CPBO groups could and would join efforts to defend public health from attacks, but need help connecting their own goals and causes to public health's work.

Many in public health reacted to attacks on the field with a defensive crouch. As one public health interviewee shared, "Public health is under attack; when under attack, you can't get people to go into more controversial areas." CPBOs are open to joining and supporting public health in response, but would like to see public health make a more explicit connection to wider attacks on government, the public sector, and peoples' movements for social justice. "I would love to do more for public health," one respondent told us, referring to underfunding of public health. "I'd like to be invited to understand the risks and challenges better and to advocate for more funding for it ... it would be nice to be more reciprocal."

Opportunities to Move Forward

Despite the disconnects in cultures and structures revealed by our interviews, public health NGOs and CPBOs have powerful **potential to work together on advocacy and policy strategies to achieve racial justice and health equity**. Many players in this landscape can contribute to stronger coordination and collaboration..

For example, **public health NGOs** in particular could identify campaigns they are willing to align with, and start by building relationships with CPBO partners and engaging in advocacy. Inside and outside of government, public health entities can join or create learning cohorts and communities of practice such as HIP's Power-building Partnerships for Health (PPH) that are dedicated to exactly this type of mutual work and understanding. They can start by developing a shared analysis of community power-building and how it is differentiated from community engagement, and get comfortable with power mapping and similar tools.

Academic public health can explore setting up "activist labs," modeled on those already in place, and/or incorporate advocacy skill-building and community power-building concepts into their existing curricula. They can set up internships, joint projects, and other collaborations that bring together public health and community power-building groups, faculty, and students.

Funders can support all of these initiatives at the local, regional, and national levels, incorporating community power-building concepts and strategies into their own theories of change and funding streams.

CPBOs themselves can reach out to public health counterparts, and welcome them into advocacy opportunities (such as data, reports, and letter writing) that begin to build trust and relationships.

To facilitate these actions, responding to the findings from our landscape scan, HIP launched the **Public Health for Community Power Coalition** to close the advocacy gap in the public health ecosystem by bringing public health organizations into relationship with CPBOs around these groups' existing policy campaigns. The Coalition envisions a coordinated public health ecosystem that is strategically advocating for the policy priorities — many of which are shared with public health — of community power-building organizations and networks, and where public health NGOs use their voice and power to align with and advance social justice campaigns and movements.

Introducing the Public Health for Community Power Coalition

HIP formally launched the Public Health for Community Power Coalition in the summer of 2024, after hosting two multi-day convenings bringing together many of the public health NGO interviewees who expressed interest in working together. It is currently comprised of 13 organizational members: American Public Health Association; Boston University School of Public Health Activist Lab; ChangeLab Solutions; Human Impact Partners; National Association of Community Health Workers; Network for Public Health Law; Partners in Health-US; Prevention Institute; Public Health Institute; the Policy, Practice, and Prevention Research Center (at the University of Illinois Chicago School of Public Health); University of Wisconsin Population Health Institute/County Health Rankings & Roadmaps; and Voices for Healthy Kids, American Heart Association.

During its first year, the Coalition is focused on establishing our structure, pursuing collective learning, and piloting advocacy collaborations with CPBOs.

Establish our structure:
Build cohesive and collaborative Coalition infrastructure to coordinate public health NGO members, and provide ongoing advocacy for community power-building campaigns and movements

Despite questions about the focus, breadth, and roles that came up in public health NGO interviews, there was widespread interest among interviewees in establishing a more formal infrastructure to take collective advocacy action in support of community power-building campaigns and movements.

To explore these desires in greater depth and begin forming relationships among public health NGOs, HIP convened many of the groups at two in-person meetings in February and June 2024. Coming out of the convenings, participants agreed to create a formal infrastructure to overcome many of the challenges identified by national organizing groups and CPBOs, including: lack of understanding of what public health does, lack of deep relationships, and lack of a bold and visible presence at the national level. CPBOs had a strong desire for public health to strategically leverage its "expert" role in support of communities' leadership and priorities. Establishing the Coalition is one strategy to achieve that goal.

As one public health NGO interviewee said, "At a minimum, [we would benefit from] building relationships at a horizontal level [across public health]...we would benefit tremendously as an organization to have access to a [space] like that, because of how fragmented public health is."

The Coalition is committed to centering relationships and an ecosystem mindset that intentionally shifts away from individual, organizational "empire-building" thinking and competitive practices, and toward collaborative, mutual relationships of trust, accountability, and reciprocity with one another and with CPBOs. Initial efforts focus on creating a steering committee; determining advocacy priorities; developing and stewarding coalitional relationships with CPBOs and networks; identifying learning/capacity building needs for members; coordinating narrative and messaging efforts; and, beginning to engage in advocacy. A public launch is planned for early 2025, and more information will be available then. Our goal is for this structure to provide the coordinated advocacy that CPBOs desire, creating a container within public health for centering the preferences and needs of those closest to the issues that both public health and CPBOs aim to address.

Pursue collective learning: Provide co-learning spaces for Coalition members and CPBOs to learn about one another and explore deeper collaborations

Our dual sets of interviews illustrated that education is needed to foster deeper relationships and collaborations. Coalition members and CPBOs have stressed a need for better mutual understanding of each other's goals, analyses, guiding frameworks, and potential roles. Initial capacity building efforts have focused on sharing information with Coalition participants about how CPBOs approach organizing and power-building, and how they do their work. Future capacity building, in shared spaces with CPBO and network partners, should focus distinguishing public health from health care; understanding how public health approaches the social/structural determinants of health and upstream root causes; using data and evidence to support community power-building efforts; leveraging health equity narrative power (e.g., emphasizing shared values); strengthening public health's accountability to grassroots movements; and recognizing the considerable benefits for each type of organization and network.

Pilot collaborations with community power-building organizations: Explore initial advocacy collaborations to build trust and work on upstream policy priorities

Coalition members have expressed strong readiness and excitement to engage in and support CPBO campaigns. An opportunity for this emerged rather quickly: shortly after the Coalition's formation,the Tenant Union Federation (TUF) sought public health support for a campaign asking the White House to direct the Federal Housing Finance Agency to implement a 3% rent cap on rental homes that received federally-backed financing. After TUF's direct request, Coalition members mobilized to author a support letter and ultimately, over 25 organizations signed on to the campaign.

It is far too soon to reflect on the success and lessons of this campaign and partnership, but this initial test indicates that the Coalition's coordinated infrastructure led to greater engagement and support for a campaign that the public health sector had not previously been involved in. It also indicates that public health NGO concerns about advocacy (as described in our interviews) are manageable and can be overcome. Last, it shows that CPBOs are receptive to partnerships with public health, and see value in their contributions.

Our hope is that this kind of collaboration will build trust, relationships, and power — and will ultimately facilitate deeper explorations of vision, values, analysis, and strategy alignment across our sectors, as well as more coordinated and publicly visible advocacy partnerships.

Conclusion

At the beginning of this report, we posed a set of questions around what could be possible if we had strong infrastructure within the public health field for deep collaboration with social movements. Those questions led to the research and findings described herein — ultimately providing the justification for HIP's launch of the Public Health for Community Power Coalition.

The onus of our coming work, rightfully, falls on the field of public health, which has largely not supported community power-building in its analyses, approaches, or existing advocacy efforts. We also know that asking public health to do more when many in the field already feel under attack may seem too heavy a lift. **Our hope is for the public health sector to understand the call to support community power–building and wider social justice movements as an opportunity for the field *to build its own power to be more effective***. It is a call for public health to return to its social justice roots, to locate itself and operate within a broader ecosystem of social justice movement and community power-building partners.

Stronger, deeper alliances with social justice movements will mean more powerful partnerships for public health. Many CPBOs in our interviews were surprised to learn about public health's structural and social determinants focus, and were excited at the prospect of partnering with public health organizations who have this emphasis. They overwhelmingly saw the connection between their issues, community power-building, and health equity. Many CPBOs are ready and willing to welcome public health into their movements, accelerating a more collective vision towards health equity and racial justice. A coordinated public health ecosystem that has the capacity and passion to support broader social justice movements is a prescription for better health and better politics, and it is increasingly evident that community power and health are inextricably linked.

Appendix A: Public Health NGO and CPBO Interview Participants

Participating Public Health NGOs

1. American Public Health Association - Alliance for Disease Prevention and Response
2. American Public Health Association - Government Relations
3. Big Cities Health Coalition
4. Boston University School of Public Health Activist Lab
5. California Alliance of Academics and Communities for Public Health Equity
6. ChangeLab Solutions
7. Health Begins
8. Johns Hopkins Bloomberg School of Public Health
9. Johns Hopkins Bloomberg School of Public Health
10. National Network of Public Health Institutes
11. The Network for Public Health Law
12. Partners in Health US
13. Public Health Accreditation Board - Center for Innovations
14. The Praxis Project
15. Prevention Institute
16. Public Health Institute
17. Trust for America's Health
18. University of Illinois Chicago - Policy, Practice, Prevention & Research Center
19. University of South Florida College of Public Health Activist Lab
20. Voices for Healthy Kids - American Heart Association
21. Anonymous (n=2)

Participating Community Power-building Organizations and networks

1. Athena Coalition [fiscally sponsored by United for Respect]
2. Climate Justice Alliance
3. Community Change
4. Center for Popular Democracy
5. Critical Resistance
6. Faith in Action
7. Gamaliel/WISDOM
8. Jobs with Justice [San Francisco & National]
9. Movement for Black Lives
10. PowerSwitch Action
11. Restaurant Opportunities Center
12. Right to the City Alliance
13. People's Action
14. The Praxis Project
15. Prevention Institute
16. Public Health Institute
17. Trust for America's Health
18. University of Illinois Chicago - Policy, Practice, Prevention & Research Center
19. University of South Florida College of Public Health Activist Lab
20. Voices for Healthy Kids - American Heart Association
21. Anonymous (n=2)